Who should we contact?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FIRST LAST

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Medical Doctor?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 FIRST LAST

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN EVENT OF EMERGENCY

Today’s Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LAST FIRST MI

Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Male □ Female

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: □Minor □Single □Married □Divorced □Separated □Widowed

Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY STATE ZIP

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext:\_\_\_\_\_\_\_\_

Other Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ABOUT YOU

The reason for this visit is a result of *(Please circle)*: work / sports / auto / trauma / chronic.

Explain what happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the pain & its location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did condition begin? \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Is this condition getting worse? □ Yes □ No / □ Constant □ Comes and goes

Is this condition interfering with your *(Please circle)*: work / sleep / daily routine?

If so please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated by a chiropractor before? □ Yes □ No

If so whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR VISIT

**WELCOME**

**MAXIMUM LIFE**

**HEALTH CENTER**

**PLEASE CONTINUE ON BACK**

**Are you taking any of the following medications?**

□ Nerve Pills □ Insulin □ Blood Thinners □ Muscle Relaxers

□ Pain Killers (including aspirin) □ Stimulants □ Tranquilizers □ Other(s)

**Do you have or ever had any of the following diseases or conditions?**

**Y N** Heart Attack / Stroke **Y N** Heart Surgery **Y N** Heart Murmur

**Y N** Congenital Heart Defect **Y N** Mitral Valve Prolapse **Y N** Artificial Valves

**Y N** Alcohol / Drug Abuse **Y N** Venereal Disease **Y N** Hepatitis

**Y N** HIV + / Aids **Y N** Shingles **Y N** Cancer

**Y N** Frequent Neck Pain **Y N** Emphysema / Glaucoma **Y N** Anemia

**Y N** High/Low Blood Pressure **Y N** Psychiatric Problems **Y N** Rheumatic Fever

**Y N** Severe/Frequent Headache**Y N** Kidney Problems **Y N** Ulcers / Colitis

**Y N** Sinus Problems **Y N** Fainting/Seizures/Epilepsy **Y N** Asthma

**Y N** Diabetes / Tuberculosis **Y N** Difficulty Breathing **Y N** Chemotherapy

**Y N** Lower Back Problems **Y N** Artificial Bones / Joints **Y N** Arthritis

Please list any other serious medical condition(s) you have ever had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please list anything that you may be allergic to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List previous surgeries / treatments with dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any **past** serious accidents with date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Health History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you:** Take Supplements or Vitamins? □ Yes □ No / Exercise? □ Yes □ No

Are you on a special diet? □ Yes □ No / Since- \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you smoke? □ Yes □ No / How Much? \_\_\_\_\_\_\_\_\_\_\_\_ How Long? \_\_\_\_\_\_\_\_\_\_\_\_

Are you wearing: □ Heel Lifts □ Sole Lifts □ Inner Soles □ Arch Supports

What is the age of your mattress? \_\_\_\_\_\_\_\_\_\_\_\_ Is it comfortable? □ Yes □ No

**For Women:** Are you taking Birth Control? □ Yes □ No

Are you pregnant? □ Yes □ No / How Long? \_\_\_\_\_\_\_\_\_\_\_\_ Nursing? □ Yes □ No

HEALTH HISTORY

**Person ultimately responsible for account**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY STATE ZIP

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.L. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment Method:** □ Cash □ Check

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Credit Card – enter card # above (We Accept All Major Credit Cards)

ACCOUNT INFO

* We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred during collecting your account.
* I authorize the staff to perform any necessary services needed during diagnosis and treatment.
* I understand the above information and guarantee this information was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_